DSS
Strong Families - South Dakota's Foundation and Our Future

Department of Social Services
Division of Behavioral Health
811 E. 10th Street, Dept. 9
Sioux Falls, SD 57103

Plan of Correction

Program Name: East Central Behavioral Health	**Date Submitted:** 10/31/2018	**Date Due:** 12/2/2018

Administrative POC-1	
Rule #: 67:61:02:21 and 67:62:02:19	**Rule Statement:** **Sentinel event notification.** Each accredited agency shall make a report to the division within 24 hours of any sentinel event including; death not primarily related to the natural course of the client's illness or underlying condition, permanent harm, or severe temporary harm, and intervention required to sustain life. Each agency shall develop root cause analysis policies and procedures to utilize in response to sentinel events. Each agency shall also report to the division as soon as possible: any fire with structural damage or where injury or death occurs, any partial or complete evacuation of the facility resulting from natural disaster, or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. The agency shall submit a follow-up report to the division within 72 hours of any sentinel event and the report shall include: 1) A written description of the event; 2) The client's name and date of birth; and 3) Immediate actions taken by the agency.
Area of Noncompliance: The agency did not have a policy and procedures related to sentinel events. One needs to be developed.	
Corrective Action (policy/procedure, training, environmental changes, etc): A new policy has been developed to address sentinel events. This policy has been approved by our Board of Directors and implemented in our facility.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Please see the attached policy document (AP-13)	**Person Responsible:** Mary Beth Fishback, Interim Executive Director
How Maintained: This policy will be maintained in the Agency Policy and Procedure Manual and will be reviewed annually.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-2	
Rule #: 67:61:04:02 and 67:62:05:02	**Rule Statement:** **Statistical data.** Each agency shall submit accurate statistical data on each client receiving services to the division in manner agreed upon by the division and the agency. The agency shall provide statistical data on all services in accordance with the state Management Information System (MIS), and the agency shall provide any other data required by the division and state and federal laws and regulations.
Area of Noncompliance: The agency has not been submitting outcome tools into STARS and will need to completed outcome tools.	
Corrective Action (policy/procedure, training, environmental changes, etc): ED participated in the training offered by the Division on utilizing outcome tools. All agency staff have been re-trained on the outcomes tools by the ED. They have been provided with copies of the manual as well as each outcome tool. Staff have	**Anticipated Date Achieved/Implemented:** **Date** 11/01/2018

been instructed to complete the tools with their clients at the appropriate time, submit the paper copies, and the ED will be responsible for imputing the information into the STARS system.	
Supporting Evidence:	**Person Responsible:** ED and Clinicians
How Maintained: Outcome tool completion will be monitored with the agency's quality assurance case record review process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-3	
Rule #: 67:61:06:07	**Rule Statement:** **Discharge policies.** Each agency shall have a written discharge policy. The policy includes the following: 1) Client behavior that constitutes reason for discharge at staff request; 2) The procedure for the staff to follow when discharging a client involved in the commission of a crime on the premises of the program or against its staff, consistent with the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. § 2.12(c)(5) (June 9, 1987) including who shall must make the report to the appropriate law enforcement agency; 3) The procedure for the staff to follow when a client leaves against medical or staff advice, including offering the client discharge planning and continuation of care for substance abuse and any other condition and documentation of what was offered, consistent with the confidentiality of alcohol and drug abuse patient records, 42 C.F.R., Part 2 (June 9, 1987), confidentiality of alcohol and drug abuse patient records; 4) Prohibition against automatic discharge for any instance of non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness; and 5) The procedure for referrals for clients with symptoms of mental illness or a medical condition and those requesting assistance to manage symptoms.
Area of Noncompliance: The agency did not have a policy on discharge; one will need to be developed.	
Corrective Action (policy/procedure, training, environmental changes, etc): A discharge policy has been developed and implemented according to Administrative Rule.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Please see the attached policy document (AP-14)	**Person Responsible:** Mary Beth Fishback, Interim Executive Director
How Maintained: This policy will be maintained in the Agency Policy and Procedure Manual and will be reviewed annually.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-4	
Rule #: 67:61:11:05	**Rule Statement:** **Criteria for determining evidence-based intervention.** Evidence based intervention is defined by inclusion under one or more of three public resources as follows:

	1) Federal lists or registries of evidence-based interventions; 2) Reported positively in peer reviewed journals; or 3) Documented effectiveness based on four guidelines for evidence which are: a) The intervention is based on a theory of change that is documented in a clear logic or conceptual model; b) The intervention is similar in content and structure to interventions that appear in registries or the peer reviewed literature or both; c) The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and d) The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review.

Area of Noncompliance: The agency had materials being used in their prevention program that did not appear to be signed off by the director. There was also no distribution material available to the public during the review.

Corrective Action (policy/procedure, training, environmental changes, etc): Executive Director will review and sign off on all materials being used and distributed for the prevention programs.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence:	**Person Responsible:** Executive Director
How Maintained: Prevention material will be reviewed on a quarterly basis.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-5	
Rule #: 67:61:11:08	**Rule Statement:** **Quality assurance and evaluation.** An agency shall conduct a quality assurance review of its prevention programming to monitor, protect, and enhance the quality and appropriateness of its programming and to identify qualitative problems and recommend plans for correcting each problem. The agency shall conduct the following: 1) Annual satisfaction surveys of all individuals or stakeholders who requested and participated in prevention services; 2) Participant evaluations after each prevention presentation the agency provides; and 3) Pre- and post-tests for all evidence based curricula presented to individuals. A summary of these reports shall be made available to the board of directors or agency staff annually, and to the division and community members upon request.

Area of Noncompliance: The agency did not have an annual summary of these reports. They did not have any pre and post tests for all evidence based curricula presented.

Corrective Action (policy/procedure, training, environmental changes, etc): A prevention program quality assurance policy has been developed and implemented to address this deficiency.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018

Supporting Evidence: Please see the attached policy document (CP-6)	**Person Responsible:** Mary Beth Fishback, Interim Executive Director
How Maintained: This policy will be maintained in the Agency Policy and Procedure Manual and will be reviewed annually.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-6	
Rule #: 67:61:05:05 and 67:62:06:04	**Rule Statement:** **Orientation of personnel.** The agency shall provide orientation for all staff, including contracted staff providing direct clinical services, interns, and volunteers within ten working days after employment. The orientation must be documented and must include at least the following items: 1) Fire prevention and safety, including the location of all fire extinguishers in the facility, instruction in the operation and use of each type of fire extinguisher, and an explanation of the fire evacuation plan and agency's smoking policy; 2) The confidentiality of all information about clients, including a review of the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2 (June 9, 1987), and the security and privacy of HIPAA, 45 C.F.R. Parts 160 and 164 (April 17, 2003); 3) The proper maintenance and handling of client case records; 4) The agency's philosophical approach to treatment and the agency's goals; 5) The procedures to follow in the event of a medical emergency or a natural disaster; 6) The specific job descriptions and responsibilities of employees; 7) The agency's policies and procedure manual maintained in accordance with § 67:61:04:01; and 8) The agency's procedures regarding the reporting of cases of suspected child abuse or neglect in accordance with SDCL 26-8A-3 and 26-8A-8.
Area of Noncompliance: In review of the orientation files, the orientation was not found to be completed within 10 days of hire.	
Corrective Action (policy/procedure, training, environmental changes, etc): Updates to the agency employment policy and new hire checklist have been completed to reflect the stated rule above.	**Anticipated Date Achieved/Implemented:** **Date** 10/01/2018
Supporting Evidence: See attached policy PP-2 Employment of New Personnel and the New Employee Orientation Checklist.	**Person Responsible:** Associate Director of Administration
How Maintained: Policy and procedure will be maintained in the agency policy and procedure manual. New hire checklists will be completed by the Associate Director of Administration and maintained in the employee files.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-7	
Rule #: 67:61:05:04	**Rule Statement:** **Qualifications of staff providing prevention services.** Agency staff providing prevention programming shall complete the Substance Abuse Prevention Skills Training (SAPST) or Foundations of Prevention within one year of hire. Evidence of completion shall be placed in

	the staff member's personnel file

Area of Noncompliance: In review of the personal files, there was no evidence of completion of either of the requirements in the staff providing prevention programming.

Corrective Action (policy/procedure, training, environmental changes, etc): ED has worked with DBH staff and will ensure our agency is made aware of upcoming trainings. All staff providing prevention programming will be properly trained within the next year based on course availability.	**Anticipated Date Achieved/Implemented:** **Date** TBD
Supporting Evidence:	**Person Responsible:** Mary Beth Fishback Interim Executive Director
How Maintained: Ongoing review of personnel files	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-8	
Rule #: 67:61:05:01	**Rule Statement:** **Tuberculin screening requirements.** Tuberculin screening requirements for employees are as follows: 1) Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; 2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; 3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of *Myobacterium* tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and 4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.

Area of Noncompliance: The documentation of each required TB skin test within the 14 days of hire was not found in the majority of the personnel records reviewed.

Corrective Action (policy/procedure, training, environmental changes, etc): This rule has been reviewed with the Associate Director of Administration and our PA to ensure compliance.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence:	**Person Responsible:** Associate Director of Administration
How Maintained: Results will be maintained in employee files and reviewed by the ED and Associate Director of Administration.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-1	
Rule #: ARSD 67:61:07:05 and 67:62:08:05	**Rule Statement:** **Integrated assessment.** An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's case record and includes the following components: 1) Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable; 2) Presenting problems or issues that indicate a need for services; 3) Identification of readiness for change for problem areas, including motivation and supports for making such changes; 4) Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization; 5) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history; 6) Family and relationship issues along with social needs; 7) Educational history and needs; 8) Legal issues; 9) Living environment or housing; 10) Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal; 11) Past or current indications of trauma, domestic violence, or both if applicable; 12) Vocational and financial history and needs; 13) Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present; 14) Formulation of a diagnosis, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder, or gambling issues

	or a combination of these based on integrated screening; 15) Eligibility determination, including level of care determination for substance use services, or SMI or SED for mental health services, or both if applicable; 16) Clinician's signature, credentials, and date; and 17) Clinical supervisor's signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or formulation of the initial diagnosis in cases where the staff does not have the education or training to make a diagnosis. Any information related to the integrated assessment shall be verified through collateral contact, if possible, and recorded in the client's case record.

Area of Noncompliance: Many of the client's assessments were missing one or more of the required elements. Ensure the integrated assessments are completed within 30 days of first appointments.	
Corrective Action (policy/procedure, training, environmental changes, etc): An Integrated Assessment Template has been developed and is currently in use with all clinicians. Clinicians work with the Clinical Director during supervision to review this document and ensure they are properly documenting all client information. Additionally, client charts will be reviewed using the QA policy and procedure.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Integrated Assessment Template and CP-1 Quality Assurance – Case Record Review	**Person Responsible:** Clinical Director and Executive Director
How Maintained: Policy will be maintained in the agency policy and procedure manual. Assessment template will be utilized by all clinicians and reviewed during the supervision process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-2	
Rule #: 67:61:07:06 and 67:62:08:07	**Rule Statement:** **Treatment plan.** For Substance Use Charts; An counselor shall develop an individualized treatment plan based upon the integrated assessment for each client admitted to an outpatient treatment program, intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically-monitored intensive inpatient treatment program. Evidence of the client's meaningful involvement in formulating the plan shall be documented in the file. The treatment plan shall be recorded in the client's case record and includes: 1) A statement of specific client problems, such as co-occurring disorders, to be addressed during treatment with supporting evidence; 2) A diagnostic statement and a statement of short- and long-term treatment goals that relate to the problems identified; 3) Measurable objectives or methods leading to the completion of short-term goals including: a) Time frames for the anticipated dates of achievement or completion of each objective, or reviewing progress towards objectives; b) Specification and description of the indicators to be used to assess progress; c) Referrals for needed services that are not provided directly by the agency; and d) Include interventions that match the client's readiness for change for identified issues; and 4) A statement identifying the staff member responsible for facilitating the methods

	or treatment procedures. The individualized treatment plan shall be developed within ten calendar days of the client's admission for an intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically monitored intensive inpatient treatment program. The individualized treatment plan shall be developed within 30 calendar days of the client's admission for a counseling services program. All treatment plans shall be reviewed, signed, and dated by the addiction counselor or counselor trainee. The signature must be followed by the counselor's credentials. For Mental Health Clients; The initial treatment plan shall be completed within 30 days of intake and shall include the mental health staff's signature, credentials, and date of signature, and the clinical supervisor's signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor as defined in subdivision 67:62:01:01(8). Evidence of the client's or the client's parent or guardian's participation and meaningful involvement in formulating the plan shall be documented in the file. This may include their signature on the plan or other methods of documentation. The treatment plan shall: 1) Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made; 2) Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client's mental health treatment; 3) Include interventions that match the client's readiness for change for identified issues; and 4) Be understandable by the client and the client's family if applicable. A copy of the treatment plan shall be provided to the client, and to the client's parent or guardian if applicable.

Area of Noncompliance: One or more of the following were missing from the SUD and MH treatment plans. Ensure each plan in individualized to the client.

Corrective Action (policy/procedure, training, environmental changes, etc): A treatment plan template has been developed and implemented with the Integrated Assessment Template (attached) and will follow the same training and review process as the Integrated Assessment.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Integrative Assessment Template and CP-1	**Person Responsible:** Clinical Director and Executive Director
How Maintained: Policy and procedure will be maintained in the agency policy and procedure manual and review annually. The treatment plan template will be utilized by all clinicians and reviewed in clinical supervision.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-3	
Rule #: 67:62:08:08	**Rule Statement:** **Treatment plan review -- Six month review.** Treatment plans shall be reviewed in at least six month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the client's treatment plan goals or objectives shall be documented in the treatment plan. Treatment plan reviews shall include the mental health staff's signature, credentials, and date.
Area of Noncompliance: In review of the CYF and CARE treatment plan reviews, one or more elements were missing from the reviews.	
Corrective Action (policy/procedure, training, environmental changes, etc): A Supervisory Review Template has been developed and implemented with all clinical staff.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Supervisory Review Template; CP-1	**Person Responsible:** Clinical Director and Executive Director
How Maintained: The supervisory review template will be utilized by all clinicians and review during clinical supervision as well as during the QA – Case Record review process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-4	
Rule #: 67:62:08:09	**Rule Statement:** **Supervisory reviews.** Staff meeting clinical supervisory criteria as defined in subdivision 67:62:01:01(8), shall conduct one treatment plan review at least annually. This review shall include documentation of: 1) Progress made toward treatment goals or objectives; 2) Significant changes to the treatment goals or objectives; 3) Justification for the continued need for mental health services; and 4) Assessment of the need for additional services or changes in services, if applicable. This review qualifies as a six month review pursuant to § 67:62:08:08. The annual supervisory review shall include the clinical supervisor's signature, credentials, and date.
Area of Noncompliance: In review of the CYF and CARE charts, one or more of the above elements were missing.	
Corrective Action (policy/procedure, training, environmental changes, etc): A Supervisory Review Template has been developed and implemented with all clinical staff.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Supervisory Review Template; CP-1	**Person Responsible:** Clinical Director and Executive Director

How Maintained: The supervisory review template will be utilized by all clinicians and review during clinical supervision as well as during the QA – Case Record review process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-5	
Rule #: 67:62:08:10	**Rule Statement:** **Crisis intervention plans.** Crisis intervention planning shall be provided to any client who has safety issues or risks or has frequent crisis situations or recurrent hospitalizations. Crisis intervention planning shall be offered to any client who may need such planning to prevent the following: 1) Hospitalization; 2) Out of home placement; 3) Homelessness; 4) Danger to self or others; or 5) Involvement with the criminal justice system. Crisis intervention plans shall be developed in partnership with the client, if possible, the client's parent if the client is under 18 years of age, or the client's guardian, if any, and include interventions specific to the client, and address issues relative to co-occurring disorders.
Area of Noncompliance: In review of the CYF, MH outpatient, and CARE charts a crisis intervention plan was not found.	
Corrective Action (policy/procedure, training, environmental changes, etc): Administrative Rule 67:62:08:10 has been reviewed with all clinical staff. Crisis intervention plans will be implemented when appropriate by clinicians and with the support of the clinical director when needed.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence:	**Person Responsible:** Clinical Director
How Maintained: Crisis intervention plans will be maintained in the client records and reviewed during the QA- Case Record review process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-6	
Rule #: 67:61:07:08 and 67:62:08:12	**Rule Statement:** **Progress notes.** For SUD charts; All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly. For both SUD and MH charts; Progress notes are included in the client's file and substantiate all services provided. Individual progress notes shall document counseling sessions with the client, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes shall include attention to any co-occurring disorder as they relate to the client's substance use disorder. A progress note is included in the file for each billable service provided. Progress notes shall include the following for the services to be billed: 1) Information identifying the client receiving services, including name and unique identification number; 2) The date, location, time met, units of service of the counseling session, and the duration of the session; 3) The service activity code or title describing the service code or both; 4) A brief assessment of the client's functioning;

	5) A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives; 6) A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and 7) The signature and credentials of the staff providing the service.

Area of Noncompliance: In review of the SUD and MH progress notes, one or more elements were missing within the progress notes. The progress notes appeared vague at times, repetitive planning for next week, and not individualized.

Corrective Action (policy/procedure, training, environmental changes, etc): A Progress Note Template has been developed and implemented with all clinical staff.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: Progress Note Template; CP-1	**Person Responsible:** Clinical Director and Executive Director
How Maintained: The progress note template will be utilized by all clinicians and review during clinical supervision as well as during the QA – Case Record review process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-7	
Rule #: 67:61:07:10 and 67:62:08:14	**Rule Statement:** **Transfer or discharge summary.** A transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate.

Area of Noncompliance: In review of the SUD and MH charts, they were missing one or more the above elements.

Corrective Action (policy/procedure, training, environmental changes, etc): Policy CP-3 Admission, Continued Service, Discharge Criteria has been updated to reflect this rule for both MH and SUD charts.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: CP-3 Admission, Continued Service, Discharge Criteria Policy attached.	**Person Responsible:** Mary Beth Fishback Interim Executive Director
How Maintained: This policy is maintained in the agency policy and procedure manual and reviewed annually. Additionally, the transfer or discharge summary notes will be reviewed with the quality assurance / case record review.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-8

Rule #:	Rule Statement:
67:61:07:12	**Tuberculin screening requirements.** A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months: 1) Productive cough for a two to three week duration; 2) Unexplained night sweats; 3) Unexplained fevers; or 4) Unexplained weight loss. Any client determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any client confirmed or suspected to have infectious tuberculosis shall be excluded from services until the client is determined to no longer be infectious by the physician. Any client in which infectious tuberculosis is ruled out shall provide a written statement from the evaluating physician before being allowed entry for services.

Area of Noncompliance: The SUD charts reviewed did not have TB screening questions completed.

Corrective Action (policy/procedure, training, environmental changes, etc): A TB Screening document has been developed and implemented as part of the client orientation paperwork. The Client Orientation Policy has been updated to reflect this addition.	**Anticipated Date Achieved/Implemented:** **Date** 10/15/2018
Supporting Evidence: CP-2 and F- TB Screening documents attached.	**Person Responsible:** Administrative Staff
How Maintained: CP-2 policy is maintained in the agency policy and procedure manual and reviewed annually. The F- TB Screening form is maintained in the front office in the client orientation packets. Once complete the form will be scanned into the client medical record and reviewed annually as part of the QA process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Program Director Signature: Mary Beth Fishback, Interim Executive Director	Date: 12/07/2018

Send Plan of Correction to:

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